

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11219  
Registrar's No. 48

Registration District No. 400

Primary Registration District No. 655313

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Little Blue  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution County Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 Days  
(Specify whether)  
In this community 20 Years  
years, months or days

3. (a) PRINT FULL NAME Mary Turner

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex Female 5. Color Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive no years

7. Birth date of deceased Don't know  
(Month) (Day) (Year)

8. AGE: Years about 65 Months - Days - If less than one day hr. - min. -

9. Birthplace Don't know  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business Home duties

12. Name Don't know

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julius A. Fischer

(b) Address 1212 Vine St

17. (a) Blue Ridge (b) Date thereof March 31-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Blue Ridge

18. (a) Signature of funeral director Julius A. Fischer

(b) Address 1212 Vine St

19. (a) 3-21-40 (b) Sarah S. Barnes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1129 Belvidere Hollow  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? - years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24  
year 1939 hour - minute 4 P. M.

21. I hereby certify that I attended the deceased from Nov 16, 1939, to Nov 24, 1939;  
that I last saw him alive on Nov 24, 1939,  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerotic  
insufficiency

Due to -

Due to ✓

Other conditions 92H  
(Include pregnancy within 3 months of death)

Major findings: ✓

Of operations -

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

(Specify type of place)  
While at work? ✓ (e) Means of injury ✓

23. Signature W. Booker (M. D. or other) ✓

Address 2028 Vine St Date signed -

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*Julius A. Fierline*

Licensed Embalmer No.

*2229*

P. O. Address

*1212 Vine St*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**